309

payers relatively weak negotiators.
Q. Would there be -- let me make sure I understand what you mean by the term "weak negotiator."
A. Yes. Let me be a little clearer.
Q. Sure.
A. I mean that in the sense that there are likely to be rents, profits in all these contracts, that payers are not able to drive physician reimbursement down to cost.
Q. Now, when you say "weak negotiators," are you referring -- are you isolating the issue of negotiation of reimbursement for physician-administered drugs? Are you speaking more broadly in terms of the overall negotiation between physicians and third-party providers on reimbursement for all fees and services?
A. What I am talking about here is really about negotiating for these physician-administered drugs.
Q. How can you isolate that when the third-party providers are negotiating an entire

310

range of services with a physician?
A. I have not been asked to provide an opinion about that negotiation.
Are you asking me --
Q. Yes.
A. -- whether I think physician make profits on other goods and services?
Q. Right.
A. Certainly, but those -- the nature of the transactions for something like open-heart surgery may be very different from the nature of the transactions related to these physician-administered drugs, and I have not examined and pulled together the information on all these other services.
Q. Does the fact that they make profits -- strike that.
Why does the fact that they make profits make the third-party providers necessarily weak negotiators?
A. My use of the term was to imply that they could not use negotiation to drive reimbursement

311

down to cost, and therefore, dissipate the effects of the spread.
An important piece of this overall story is that there are margins for physicians here. If there were no margins --
Q. Physicians wouldn't provide the services?
A. Presumably. Because they are oligopolists.
Q. Why are physicians oligopolists?
A. Because of licensure. There is a guild. It's called the Medical Association. Physicians have restricted entry.
There are a large number of reasons why the physician market is not competitive, including my earlier statement, as you were reading about the inability of patients to easily trade off one physician against the other.
Q. You indicated earlier in your testimony that third-party providers tend to come up with a rate schedule.
Is that rate schedule then, in your experience, typically provided to all members of

312

the network?
A. My understanding, typically, the way fee schedules work is there is a fee schedule and providers may have different multipliers off that schedule.
It may be possible that some providers negotiate different multipliers for different subsets of services.
Q. Would you agree with me that the leverage of a -- the leverage in a negotiation between a physician or physicians group and a third-party provider will vary from provider to provider and physician group to physician group?
A. I would agree with you that there may be variation and market power on both sides.
Q. And are there instances which the third-party provider has market power?
A. Certainly.
Q. So, for example, if you had a third-party provider with a significant market share in a relatively large urban area, that would -- those types of factors would tend to give the third-

313

party provider market power; would it not?
A. A third-party payer would have greater market power to the extent that they covered a larger share of the patients in an area, but I think it's important to note, again, that I wouldn't expect that to drive reimbursement of cost for physicians.
Q. And you wouldn't expect it drive down cost because the physicians still have some degree of leverage?
A. That's correct.
Q. Turn to Page 13 of your report.
A. I am on Page 13.
Q. Paragraph 26, the last sentence.
A. Okay. Yes.
Q. You say, "In the Medicare context, these negotiations take the form of Congressional action in an environment of intense lobbying by specialty societies, but have a largely similar outcome to the private process."
When you referring to the intense lobbying by specialty societies, what you are

314

referring to?
A. In this particular case, the lobbying that we've observed by the American Society of Clinical Oncologists is particularly what I had in mind.
Q. How would you characterize that lobbying?
A. They issued numerous reports and communicated with Congress about their concern for oncologists losing money on Medicare, essentially.
Q. And how would you -- do you think that lobbying has been effective?
A. I do think that lobbying has been effective.
Q. And has that lobbying resulted in levels of -- in the levels of reimbursement under Medicare Part B that have been observed over time?
A. I'm sure that lobbying is a factor, and again, the ability of physicians broadly to maintain profitability in these kinds of negotiations, yes.
Q. Would you agree with me that -- strike that.

315

Do you have an opinion of whether lobbying by the specialty societies you've identified resulted in the reimbursement levels for physician-administered drugs under Part B that were in place during the class period?
A. Again, there are numerous factors that are likely to have affected the final level that was set.
I believe that lobbying would have been a factor would have influenced it.
Q. Page 13, Paragraph 27, there is a discussion of barriers to entry.
A. Yes.
Q. You say, "Barriers to entry allow current market participants to enjoy excess profits."
What market participants are you talking about?
A. Specialist physicians, in particular, I am talking about here.
Q. And when you refer to the excess profits, are you referring to economic profits?
A. That's correct.

316

Q. What's your working definition of economic profits?
A. Well, working definition? I mean, perhaps it's not fair to say I was being precise about economic profits, which would include opportunity costs, and so the notion of profits here I am talking about, again, relates to the reimbursement levels that exceed, in this case, acquisition costs for the drug.
Q. Assuming for the moment you use the term "profits" here to refer to economic profits, did you -- would you include in there the cost of the physician operating his or her business?
A. That would certainly be part of the economic costs.
Q. And would you include opportunity costs in that?
A. It would certainly be part of the economic costs.
Q. And to what extent did you try to calculate economic profits?
A. It was not necessary for my conclusions to

317

calculate it.
It was a well-known fact in health economics that competition does not lead -- there is no perfect competition in healthcare, as we talked about very early on yesterday, and therefore, the conclusion is that there is excess profits among providers.
Q. So I want to make sure I understand your point.
A. Yes.
Q. Your point is excess profits exist in a market where there is less than perfect competition?
A. Where these physicians have market power, and therefore, do not -- do not compete in the sense of offering pricing at their cost, then that's true, there are excess profits.
Q. I just want to understand your principle, taking it outside --
A. Okay.
Q. -- the specifics of this case.
A. Okay.

318

Q. When you refer to "excess profits," are you referring to those profits which are generated by market participants where there is less than perfect competition?
A. I'm sorry, could you restate it again? I want to make sure.
Q. I will try and say it more directly.
A. Okay. Thank you.
Q. Is it your opinion where there is less than perfect competition, there will be, by its nature, excess profits?
A. What I am referring to here is the situation where there is not perfect competition. There is market power on the part of physicians. Therefore, they do not compete, and therefore, they retain excess profits.
Q. So am I correct that it is your view that the in absence of perfect competition in a market the market will generate excess profits?
MR. MACORETTA: Objection. Go ahead.
A. For the market participants who are exhibiting oligopoly behavior, yes.

319

Monopolist competition is more appropriate for physicians.
Q. Have you measured the effects of the barriers to entry to which you refer on physician economic profits?
A. I have noted, I believe, in my earlier report, that oncologists' income is considerably higher than other physicians.
If you mean that measuring -- that's a measure of again the profitability looking at the profitability as a measure of the lack of competition.
Q. And what conclusion do you draw from the fact that oncologists have higher incomes than other physician groups?
A. Well, in that particular case, these were oncologists that practiced in clinics and a large share of their income was maintained through reimbursement for injectable drugs, and I concluded that they had the ability to reap those profits despite whatever competition there was on the health plan side.

320

Q. Am I correct that it is your opinion that excess profits exist because of physician market power?
MR. MACORETTA: Objection. Go ahead.
A. In this case, market power clearly has a role to play.
Excess profits among the oncologists that we see I also attribute to the claim that we are discussing here, that AWP was inflated.
Clearly that contributes to some of their excess income, that ability to hide these additional profits, but is market power a factor in their profitability? Absolutely.
Q. To what extent have you determined the degree to which market power as opposed to anything else have contributed to the excess profits which you describe?
A. The analysis doesn't rely on quantifying that.
Dr. Hartman's analysis quantifies the extent of the overcharge, as you know, and my analysis looks at the mechanisms and examines

321

evidence that those mechanisms were in play.
I can establish my conclusions without specifically quantifying the effect of market power on profits.
Q. Would I be correct that neither you nor Dr. Hartman have determined the extent to which any spread that exists is a function of physician market power?
A. I cannot say what went into Dr. Hartman's calculations in terms of the conceptual basis for those.
Q. Let me take you to -- let's go to -- turn to Page 19. Let's use the Remicade chart as illustrative.
We are showing a 31 percent spread.
A. Okay.
Q. What part of that spread is attributable to physician market power?
A. Let me say, again, in Dr. Hartman's analysis, my understanding of the but-for world is represented by his yardstick, and so in the but-for world, the difference according to his

322

yardstick would be one percent.
Q. So I am clear, as you read Dr. Hartman's report, 30 percent of the spread would be attributable to physician market power and one percent would be attributable to other factors?
A. No. I'm sorry. Perhaps I wasn't clear.
Q. Okay.
A. I am saying the identified amount that, according to his yardstick, is identified with the alleged fraud, is that amount over the yardstick.
The rest may be due to market power, other factors, and again, it's not -- I have not identified, quantified the amount of market power that goes into that spread.
Q. So let me try to restate --
A. Okay.
Q. As you read Dr. Hartman's report, as an economist, what you see him saying is that -- using the example of Remicade -- a spread of 30 percent would be attributable to physician market power or other factors and the one percent to get us to 31 percent would be attributable to the

323

conduct alleged here in the complaint?
MR. MACORETTA: Objection. Go ahead.
A. My interpretation is a comment of what a but-for scenario is intended to look at, which is again a marginal analysis, and that here the marginal analysis suggests what could be contributed to the alleged fraud is the one percent, and therefore, everything else is attributable to the something else.
Q. And if we look at the spread in 2003 in your chart, it's 34 percent.
So the amount attributable to the alleged fraud would be four percent?
A. That's my understanding of the way the yardstick is used.
MR. CAVANAUGH: Why don't we take a short break.
MR. MACORETTA: Sure.
THE VIDEOGRAPHER: 11:47. We are off the record.
(A recess was taken.)
THE VIDEOGRAPHER: Stand by, please.

324

The time is 12:07 p.m. We are back on the record.
MR. MACORETTA: Bill, I think Dr. Rosenthal wants to supplement one of her earlier answers before you go any further.
A. Thank you. I will be brief.
I had the opportunity to look at the Dyckman survey while we were breaking, and to refresh my memory about the methods there, I just wanted note a couple of things, if you have a copy, I could read the questions for you.
Q. I actually don't.
A. I left mine back in the office, but let me tell you a couple of brief things about that.
Q. Sure.
A. The survey respondents covered approximately 45 million lives, which is about a quarter of the commercially insured population of the U.S. I know that was one of your questions, was the representative of the survey.
The questions were of an open-ended form. The question, in particular, with regard to

325

physician-administered drugs -- and I don't have word for word, I was going to read it to you -- but, essentially, how do you reimburse for physician-administered drugs? And the answers as tabulated by the researchers all were a numerical percentage of AWP.

So it leaves little ambiguity that they understood the question and were able to respond to it.

Q. All right. Let me be clear.

Am I correct that the Dyckman studies utilized open-ended questions?

A. That's correct.

Q. And would you agree with me that the utilization of open-ended questions can lead to difficulties in collecting -- strike that.

Would you agree with me that utilizing open-ended questions in a survey can be problematic?

A. In some context, where there are a wide range of ideas that might be captured by the question, that could be problematic.

326

Again, looking at this particular survey and the responses, I do not have questions about that.

Q. Do you know what the narrative responses were by these 29 individuals?

A. The researcher?

Q. 33.

A. They do not provide that information.

Q. So your reliance -- in ascertaining what the actual responses were, you are relying on the numerical tabulation done by the researchers?

A. Yes, I am.

Q. You don't know what assumptions or judgments were made by the researchers in taking the narrative responses provided by the 33 respondents and conforming that to the numerical tabulations that appear in the report?

A. Given that the tabulation represents percentages of AWP, my judgment is that very few assumptions would need to be made there.

Thank you.

Q. If you could turn to Paragraph 45 of your

327

report, which is on Page 21.

A. Yes, I have found it.

Q. You go on to talk about why payer knowledge would not have dissipated the impact of the AWP inflation.

Are you saying there that if payers knew actual acquisition costs there still would have been AWP inflation?

A. Excuse me, could you repeat the question again?

Q. I will re-ask it more broadly.

Is it your opinion that even if there was payer knowledge of physician actual acquisition costs that there nonetheless would have been AWP inflation?

A. The point that I was trying to make here was that payers had not sought out information on the acquisition costs, and therefore, because of -- excuse me -- not "therefore." It goes in the other direction.

Payers did not seek out this information because these specialty drugs were

328

among a number of concerns they had, and given the costs of seeking that information that we talked about yesterday, they relied on AWP as a benchmark for reimbursement.

Q. Now, do you have an opinion as to how difficult it would have been to determine the types of acquisition costs that physician were paying for the drugs at issue in this case?

A. It's my opinion that it was of sufficient cost that payers did not obtain that information. So some degree of difficulty.

Q. Did you attempt to determine how feasible it would have been to gather information about actual acquisition costs?

A. I reviewed the available data sources, including IMS and Verispan and found that publicly available data to get to acquisition cost was not available, and that would have been used -- considered by third-party payers.

Q. Can you look at Exhibit Rosenthal 003, which was the Barons article from 1996.

A. Okay. Yes.

329

MR. MACORETTA: Exhibit Rosenthal 011.
THE WITNESS: Thank you. I have it. Who could forget?
Q. And as we talked about yesterday, does this article report on spreads between AWP and actual costs and express them as percentages?
A. That's my understanding of what it shows, yes.
Q. And would you agree with me that the percentages expressed here are certainly outside the range of Dr. Hartman's AWP-minus-30-expectation theory?
A. That's what it appears to me.
I can't entirely see these numbers, but they appear to be in the range of about 60 percent below AWP, which is a somewhat different benchmark, but, yes, 60, 70.
Q. There's a couple of nineties.
A. Yes. I see that. Okay. So, yes.
Q. Well, in doing your work in this case, did you consider how it was that a Barons reporter was able to get this information and how

330

difficult it would have been for some of the largest insurance companies in the world to get comparable information?
MR. MACORETTA: Objection.
A. My conclusion was that insurers are looking to gather -- if they were to try to gather acquisition costs on all their providers for all of the drugs at multiple points in time, that that would indeed be costly.
This is a single point in time, and I can't read the sample, but it looks like there were a half a dozen suppliers.
Q. So your opinion is that no insurer would have any incentive to do some sort of snapshot to see -- to look at real market conditions, real acquisition price at any point in time?
A. It is my opinion that the payers actually relied on AWP, and my conclusion is that the costs of obtaining acquisition costs directly from providers, if that were even possible, were excessively high.
Q. How would it have cost Aetna to do a

331

survey of acquisition costs in 1996?
A. I did not examine that.
Q. Do you think they could have afforded the research effort that was undertaken by this reporter at Barons?
A. My judgment is that a single-point-in-time survey for a few providers would not have been the actionable information that one could use to change the reimbursement system and move it to a basis of acquisition cost.
Q. So if I understand you correctly, your opinion is that if a large insurer such as Aetna or Cigna or any of the others had gotten information on actual acquisition costs at any given point in time they would not have taken any action?
MR. MACORETTA: Objection.
A. No. That's not my opinion.
Q. Okay. What is your opinion?
A. My opinion is that they did not seek out that information because of its cost and because of the general expectation that AWP -- and

332

discounting off of AWP. So that AWP was not equivalent to acquisition costs, but that it reasonably represented average acquisition costs.
Q. You are an economist. You just used the term "cost."
So please tell me everything you did to determine what the cost would have been for them to undertake that effort?
A. I did not estimate. I did not attempt to quantify the cost.
I observed their behavior, their continued use of AWP.
Q. And based on that, you are making the assumption that they concluded that it would have been too costly to acquire actual acquisition information?
A. That is one of the conclusions that I draw from that, and that's the purpose of this paragraph, is to point that out.
Q. But you are not saying it would have been too costly for them to undertake the type of effort that is reflected in this Barons article?

333

A. I am suggesting that the kind of effort that is represented in this Barons article small snapshot, and that it would not have been useful for changing the basis of the reimbursement system.

I don't know what the work in the Barons article cost.

Q. And what is the basis for an opinion that a snapshot of actual acquisition costs would not have been sufficient to alter payer behavior?

A. The basis of my opinion is my understanding about how claims payment systems work; and the way claims payment systems work currently, there is an AWP that is referenced to generate a threshold level of the allowed amount, that's the nature of reimbursement.

If you were going to move your system to acquisition cost, it would need to put that information in.

Q. So. Doctor, if you acquired actual acquisition prices and you determined there was significant variation between your AWP-based

334

reimbursement and actual acquisition costs, couldn't insurers have adjusted the AWP-based reimbursement?

A. They could have. I think we are talking about the use of acquisition cost for reimbursement.

Q. No. I'm talking about acquiring actual acquisition information, and then the range of options that are then available to a payer.

Would you agree with me that there would be a range of options available to a payer?

A. If a payer conducted a survey of its own providers, could it have used that information in some way? Certainly.

Again, we know they continued to discount off of AWP.

Q. And had they chosen, they could have altered the AWP reimbursement rate, correct?

A. Perhaps that's true.

Q. Did you inquire of any third-party providers whether they did any snapshot surveys?

A. I did not.

335

Q. Would you agree with me that insurance companies -- strike that.

Do you have an opinion as to whether any of the third-party payers that are members of the class here are sophisticated?

A. I do not have an opinion with regard to whether they are sophisticated.

Q. So you have no opinion as to whether a health insurer such as Aetna is a sophisticated company?

A. Sophistication is not a measurement I am used to taking. So I cannot tell you that.

If you want me to tell you that Aetna is a large company, I can tell you that.

Q. You have no opinion as to the degree of sophistication or knowledge of any of the third-party plans in this case other than to say they are large- or small- or medium-sized?

A. I can tell you whether they are not-for-profit or for-profit if I exam them.

I can tell you what their profitability is, but sophistication, I don't know

336

had what you mean by that, nor would I know how to quantify it.

Q. In proffering your opinions here, have you made any assumptions regarding the internal decision-making processes of any of the third-party payers?

A. In my report --

Q. Yes.

A. -- do I rely on any assumptions about the third-party payers?

My principal assumption is that they can't observe the acquisition costs of the physicians.

Q. They --

A. I'm sorry, they cannot observe the acquisition costs.

Q. Do you make any assumptions of their conduct based on that -- on that assumption?

A. If I understand you correctly --

Q. Strike that.

What assumptions do you draw from your assertion that payers did not have access to

337

actual acquisition costs?
A. My conclusions are drawn on the basis of the notion that third-party payers were forced to contract, as they do in many cases, on the basis of imperfect information.
They don't have access, in this case, to the acquisition costs. So they used what they believed to be a signal for that, the AWP, and that that was the basis for contracting -- so that's the behavior that I examined based on that assumption that they could not use the physicians' actual acquisition costs for contracting purposes.
Q. You note at one point that, "It is possible to quantify the importance of variation in payer knowledge of the spread using Dr. Hartman's revealed preference approach."
Can you explain to me what you mean by that?
A. An outer-bounds notion of the amount of that variation could be observed in the actual percentages of AWP that were used for reimbursement.

338

Q. What do you mean by "revealed preferences"?
A. Again, the notion -- it's modeled after the general economic theory where we observe the market equilibrium, and rather than observing individual preferences, we see what happens in the market, and we infer from that something about preferences.
Q. Is a revealed preference essentially determining what choices are being made by market participants?
A. So the standard way of thinking about revealed preference is we observe choices and that reveals information about the preferences.
Q. What are the choices that you considered payers made with respect to the utilization of AWP?
A. The payers reimbursed physicians for these drugs as a percentage of AWP, which ranged -- the outer bounds -- plus or minus 15 percent, and the majority of the data in that Dyckman survey are between 90 and a hundred percent of AWP.

339

Q. Do you have an opinion as to whether payers wished to reimburse physicians at cost?
A. I'm not sure what you mean by "wished."
Q. In choosing the reimbursement rates that they did, did payers intend to reimburse physicians at cost?
A. I don't know what their intentions were.
Again, we talked about the existence of market power.
Q. Do you see any revealed preference from the utilization of AWP reimbursement rates with regard to the amount, if any, of physician profit that third-party providers were willing to allow?
A. What I observe in those reimbursement rates is generally that -- across that range, there's evidence that profits were being allowed there, yes. Is that what you are asking me?
Q. Yes.
A. So it's clear that the reimbursement allows for some profits, and there is a variation in that amount of profits, but again that the variation was, in my view, relatively narrow.

340

Q. Is it your testimony that preferences are really the same as expectation?
A. No, not at all.
"Preference" is a term we usually use about individuals rather than firms.
Using the term "revealed preference" was an attempt to make an analogy, and so the actions of a firm, in this case, under asymmetric information, will be based, in part, on what they believe the distribution of the underlying costs to be, what they believe the mean to be.
If that's what you mean by "expectations," yeah.
Q. Let me go back to your prior answer with respect to payers permitting physicians to profit on reimbursement for drugs.
Do you have an opinion to whether payers had made a decision as to the amount of profit to allow?
A. I conclude that they made some decision about that.
Do I know that exactly? What decision

341

was made? I do not.
Q. What decision do you think they made with respect to physician profit?
A. Coming up with that particular threshold was not the subject of my report. So I have not tried to quantify exactly how much profit they were allowing, they were intending to allow physicians.
Q. Let me ask you to turn to Page 14 of your report.
A. Okay. I am with you.
Q. Your opening sentence refers to physicians as the key decision-makers for most therapies, including those that are the subject of the allegations in this matter.
Would you agree with me that that would not be true with respect to the selection of a particular generic form of a drug?
A. That would be true. A physician may choose to write a brand name prescription or a generic form, but that is true, they do not choose the particular generic.

342

Q. So is there any economic incentive to pharmaceutical manufacturers with respect to incentiving doctors as it relates to generics?
A. As it relates to the generics, it is for the retailer, not for the physician.
Q. So your opinions with respect to manufacturer financial incentive -- manufacturer incentives and physician incentives would not be applicable to generic drugs?
A. Actually let me amend for a second.
Q. Sure.
A. If a physician is carrying a particular drug and distributing out of his or her office, then the selection of the generic to have in the office would still pertain to that physician's decision.
If the physician is ordering a drug that is then filled elsewhere, they can't select the generic; but if I am delivering an injection in my office, I choose which of the generics to carry, right. So it would depend.
Q. You note in your report that generic drugs

343

such as albuterol were reimbursed, not based on their AWP, but rather the median AWP?
A. That's correct.
Q. What's your understanding of the term "median"?
A. If you rank the drugs based on the price and you take the one where there is 50 percent above and 50 below, you split the difference, if it is in the middle, it's the middle in terms ranking of price, 50 percentile.
Q. If we assume that reimbursement is based on a median, then what particular incentive exists for a physician to utilize a particular generic?
A. So a physician, again chooses a generic, relative to that median AWP, will seek the generic with the lowest acquisition cost.
Do we agree?
Q. How does the physician know what the median is going to be for purposes of determining the reimbursement?
A. Physician billing software has some

344

assumption built into it. When they bill, they know how much to bill for these drugs.
Q. Did you do any effort to study the extent to which physicians were looking at their acquisition costs for the particular generic they might utilize and what the median -- what the reimbursement was based upon some median of AWP for a range of generics?
A. Did I look at individual physician billing systems? I did not. I am certainly familiar with the office billing software.
Q. Let me just make sure we are on the same page here as to the application of median in this case?
A. Sure.
Q. If I have a data range of let's say $1, $3, $5, $7 and $10, the median would be $5, right?
A. I agree with you.
Q. If I am a generic manufacturer selling at $3 and I lower my price to $1, the median stays at $5, right?

345

A. That's correct.
Q. So would I be correct that to the extent that a manufacturer lowered their price from $3 to $1, they would not be altering the reimbursement rate for that particular -- for those generic drugs?
A. All other things equal, that would be true.
If there is a competitive response to the generic manufacturer lowering their price, then the median might move, but all other things equal, that's true.
Q. In your report, you refer to the class being economically injured.
What do you mean by "economically injured"?
A. They paid more for these drugs than they would have in the but-for world.
(Exhibit Rosenthal 014 was marked (for identification)
Q. We have marked as Exhibit Rosenthal 014 a document from Managed Healthcare Executive entitled

346

"New MNA Methodology For Drug Prices is a Big Change For Many Payers. "
A. I see this. Thank you.
Q. Are you familiar with this article?
A. I am not familiar with this particular article.
Q. We had -- I asked you some questions yesterday about bad debt on co-pays for physicians.
A. Yes, you did.
Q. And you indicated to me that you had seen a report that indicated it was a negligible amount.
Was it well below one percent, what you were recalling?
A. I mentioned this was an OIG report, and I don't have the numbers in front of me.
My recollection was that they believed it to be negligible, and my estimate was that it couldn't have been more than one percent for them to say that.
Q. And do you remember when that OIG report

347

was from?
A. I don't remember the date of it, no.
Q. Have you looked at any recent data on bad debt associated with Medicare Part B co-pays?
A. I have not.
Q. Let me ask you to look at the bottom paragraph on the first page. If you'd just read that paragraph.
A. I see that.
Q. There is a sentence there, "Today physician providers collect about one-half of the drug-related co-pay."
A. I see that.
Q. Did you take that into consideration in formulating your opinions here?
A. Well, as I mentioned, I haven't seen these data, but that would not affect my opinions.
Q. Well, would you agree with me that an individual who did not make their drug co-pay under Part B certainly was not injured by any AWP inflation?
A. I'm not sure I would agree with that. I

348

would have to give that some thought.
Q. Well, if they didn't pay, how could they have overpaid?
A. I guess that would be the conclusion, but an individual in every case didn't pay, I am not sure what this half of drugs -- so it may be an individual didn't pay on some event, not others, but in theory, if there is no payment, it's hard to disagree with you.
Q. When we were talking earlier about economic profits, would you agree with me that in trying to determine what physician economic profits were on reimbursement for physician-administered drugs one would need to take into consideration the degree of bad debt on co-pays?
A. If there is a valid estimate out there, and we are trying to assess the impact on consumers -- of course this is with regard to consumers -- there is no implication that the supplemental insurer Medigap plans also didn't pay. That, I would be surprised to hear, because they are contractual obligated to pay.

349

So one might need to take that information into account in looking at the individual consumers which represent about 15 percent of the Medicare population, that's right.

Q. When you say 15 percent, are you saying then that 85 percent are covered by Medigap?

A. 15 percent is the most recent number that I have available that don't have supplemental insurance.

All that would have changed with the new drug benefit, in an unknown direction, because of course we are talking about coverage for co-insurance here.

Q. Now, your 15 percent was from a point in time before the change -- the recent changes to Medicare drug reimbursement?

A. Right. So the existence of an outpatient drug benefit may have actually decreased the amount of supplemental coverage for co-insurance. Those things were linked in the past.

MR. CAVANAUGH: All right. Doctor, I don't have any further

350

questions.

THE WITNESS: That's the best news I've heard all day.

MR. FLYNN: I am going to be ten minutes.

MR. MACORETTA: I don't think lunch is here.

THE WITNESS: That's fine.

CROSS-EXAMINATION

BY MR. FLYNN:

Q. Okay. We are still on.

Dr. Rosenthal, good afternoon, and my name is Michael Flynn. I represent AstraZeneca. I have a couple of follow-up questions from the questions Mr. Cavanaugh asked you.

I think we established before, I'm I correct, that Pulmicort is not mentioned in your report at all; is that correct?

A. That's correct. It was in the earlier complaint, but it is not in my report.

Q. You have rendered no opinions with respect to Pulmicort, correct?

351

A. That's correct.

My opinions generalize to marketplace, but I have rendered no opinions specifically with respect to Pulmicort.

Q. And the backup data that you provided, that was produced to defendants in this case supporting your analyses, includes no data with respect to Pulmicort; is that correct?

A. That's correct.

Q. Doctor, if you turn to your report Page 17, I believe, and you were talking in response to a couple of questions by Mr. Cavanaugh earlier about the implications of the implementation of LCA.

Do you remember that?

A. Yes, I do.

Q. And you have on the chart on Page 17 of your report, a little box at the top of that chart that says, "Most carriers implement LCA policy by January 1, 1999."

Do you see that?

A. Yes, I do.

352

Q. What do you mean by "most"?

A. We looked at the distribution of states over time and more than half of them had implemented by this point.

Q. And I don't see anything in your report that supports that conclusion.

What did you rely on to support the "most" conclusion that you draw with respect to the implementation of LCA?

A. The existence of the LCA policy is of public record.

It's The Center For Medicare, now, currently. It was HCFA at the time.

The Center of Medicare and Medicaid Services implemented this policy, and the carriers adopted it.

Q. I guess what I was getting at is the timing of the implementation of LCA.

You say by January 1, 1999, most carriers had implemented LCA.

What is your support for that timing conclusion?

353

A. That information comes from The Center For Medicare and Medicaid Services. If you need a particular link, I could provide that.
Q. Is it referenced as the materials you rely upon in Exhibit B to your report at all?
A. I don't believe it is, no.
Q. You drop a footnote on Page 17 that -- Note 36 -- "The LCA policy was adopted by HCFA carriers beginning in May 1997 with South Carolina and was ultimately used by almost all states."
Do you see that?
A. Yes, I do.
Q. Did you do any analysis of the number of units covered by LCA or the number of covered lives covered by LCA since the first adoption of LCA by any state?
A. I didn't do that for this chart, which again, was sort of looking at a specific point in time. So, no, I did not.
Q. Can you tell me today how many covered lives were implicated by the LCA adoption by

354

carriers prior to January 1, 1999 as opposed to after?
A. I can't quantify that, no.
Q. And you can't tell me how many units of Zoladex and/or Lupron were affected by LCA either before or after January 1, 1999; is that correct?
A. It wasn't necessary to quantify that for my analysis. So, no, I can't.
Q. The answer is no?
A. The answer is no.
Q. Dr. Rosenthal, if I understand your testimony correctly, you cite two Zoladex documents in your report that were produced by my client AstraZeneca, for an illustrative purposes, to show the incentives that were facing AstraZeneca in connection with its price decisions as to Zoladex is that correct?
A. That's correct.
Q. And because you are assuming that the allegations of the fraud in this case are true, you are not citing those documents as support for the conclusion that fraud was committed by

355

AstraZeneca in this case; is that correct?
A. I am citing those documents as support that the model that I have offered here of competitive strategy in an environment where costs are unobservable physicians are making decision, that that document suggests that competitive strategy was the reason for AWP inflation.
Q. So those documents -- I misunderstood your testimony then. I thought you said that those documents were illustrative of what you observed by looking at the economic data as to the incentives facing AstraZeneca or the other manufacturers in the case.
MR. MACORETTA: Objection.
You can answer.
A. I believe that I said the same thing. Maybe it's just a matter of language.
Those documents are additional support for the economic analysis I did of the incentives.
They corroborate my economic analysis. They look at strategic incentives from the words of the defendants themselves.

356

Q. But because you are not opining on whether or not fraud was committed in this case, you are not citing those documents as support for the conclusion that the plaintiffs' allegations are correct; is that right?
A. I am not making a legal opinion about fraud. Is that the basis for your --
Q. Just that anyone was misled or deceived, whether or not it's a legal conclusion or not, you are not opining on whether or not anyone was misled in this case, correct?
MR. MACORETTA: Objection.
Go ahead.
Q. Your opinions don't go to whether or not a particular member of the class or the class in general was misled; is that right?
A. My opinion is that the health plans relied on AWP and -- as a signal of acquisition cost, and it was not.
In layman's terms, I would consider that to be misled, but it sound to me like you are using a very specific legal connotation for that.

357

Q. No. I am just trying to get at your testimony before and in your report.
You are assuming the truth of the allegations. You're not changing that testimony; is that correct?
A. That's correct.
Q. And in referencing the AstraZeneca document in specific, the two that you referenced related to Zoladex, tell me again how you picked those documents?
A. I examined -- looked for strategic documents. I asked for strategic documents that mention AWP, and these were examples that illustrated the point that I was trying to make that the manufacturers understood AWP could be used to increase sales.
Q. And whom did you ask to find those documents?
A. The staff at Greylock McKinnon.
Q. And did you consider specific Zoladex strategic plans in your analysis?
A. Did I consider specific strategic plans --

358

Q. Are you aware of AstraZeneca had strategic plans throughout the class period as to Zoladex and its marketing and its pricing?
A. It is my understanding that pharmaceutical companies have these strategic plans for all of their products.
Q. You didn't see any of those with respect to the Zoladex, particularly in rendering your opinions in this case?
A. I did not rely on those particularly.
Q. Did you review any of them?
A. Again, I looked at a variety of the discovery materials.
The ones I relied on are cited here. So I don't believe I saw any strategic plans.
Q. So you picked two documents out of -- do you know the number of how many Zoladex-related documents were produced in this case?
MR. MACORETTA: Objection.
A. I do not.
Q. You didn't check, did you, the deposition testimony of any AstraZeneca witnesses as to the

359

very documents you selected, did you, in rendering your opinions in this case?
A. I did not.
MR. MACORETTA: Objection.
Q. You didn't check to see what they said about the context of those documents?
A. That was not what I was asked to do in this case. I did not.
Q. You didn't check as to whether or not those documents were signed off on by -- the documents you cite in your report signed off by decision-makers at AstraZeneca, correct?
A. That's correct.
Q. In your academic -- you testified in response to some of Mr. Cavanaugh's questions that you don't quantify or are not familiar with the term "sophistication" in your economic analysis.
In any of your academic or expert work have you ever observed that an entity was either sophisticated or not sophisticated?
A. I certainly can't say -- have you ever

360

used that term?
Q. I am wondering, you said that you were not familiar with how one would go about analyzing whether someone was sophisticated or not.
I was wondering, in your other academic or expert work, have you ever made observations relative to sophistication?
MR. MACORETTA: Objection.
A. I may have.
Q. Going back to the chart on Page 17, again, you posit a theory, which I believe you characterize as an events study that the implementation of LCA by a date certain that you have picked changed the incentives for AstraZeneca relative to what you characterize as AWP inflation; is that right?
A. That's right.
Q. And I think in response to questions by Mr. Cavanaugh you acknowledge that after that date under your theory AstraZeneca could have still inflated AWP, to use your words, by providing greater discounts; isn't that correct?

361

MR. MACORETTA: Objection.
Q. You can answer.
A. I think I did say that they might continue to compete by offering additional discounts and that might increase the spread.
Q. If you look at your chart, am I correct that after your January 1, 1999 date, in the data you have here, the AWP for Zoladex does not go down?
A. That's correct. It appears to be flat.
Q. So there is no additional AWP inflation, under your theory, after January 1, 1999; is that correct?
A. There is no -- there is no additional AWP inflation. I think it's a fact, yes.
Q. And by that you mean, as you mentioned in responding to Mr. Cavanaugh's questions, that AWP inflation could include leaving AWP steady, but giving greater discounts that had the effect of reducing ASP, correct?
A. In theory, the spread can be driven in either way.

362

I should note there is a spread, nonetheless, of nearly 150 percent during that time period. So there is no change in the spread.
Q. There is no additional inflation after that point?
A. There is no incremental inflation, no.
Q. In looking at your events study, as you characterize it, regarding LCA, did you check any AstraZeneca-specific company documents regarding why it made various pricing decisions as to Zoladex after January 1, 1999?
A. As I mentioned earlier, the model of research design for an events study is to look at a point in time, and all those other factors are assumed equal, or at least not confounding with the particular timing of this event.
Q. And how would you know whether specific issues being addressed by decision-makers at AstraZeneca are confounding to your theory without looking to see what their reasons were for making price decisions on Zoladex?
A. As in standard economic research, those

363

are assumptions of the research design.
Q. So your quote-unquote events study is just assuming your theory and not trying to determine whether or not there are any confounding factors in the evidentiary record in this case, correct?
A. No. In fact, it's a way of testing the theory by looking at a point in time over a short period of time and examining whether the data conform with that theory.
Q. But there is -- you don't have any knowledge as to whether or not people at AstraZeneca believe that they would not either increase AWP or provide additional discounts because of the implementation, by your conclusion, that most carriers to implement LCA, correct?
MR. MACORETTA: Objection.
A. That's correct, I did not look for those data.
Q. Okay. They are not relevant to your analysis?
A. It is not relevant to my analysis.

364

Q. I think you said in response to Mr. Cavanaugh's questions yesterday that in reaching your conclusions in this case with respect to Zoladex, you did not consider the fact that there was publicly available data with respect to the acquisition cost of Zoladex that showed discounts greater than Dr. Hartman's minimum standard of liability, correct?
A. I'm sorry, there is lot of statements in that sentence.
Could you repeat or perhaps could she read it back.
Q. I could repeat it.
I think you said yesterday you didn't consider in reaching your conclusions in this case that the IMS schedule, for example, showed discounts of greater than 30 percent with respect to Zoladex at various points in time in the class period; is that right?
A. No. That's right. I didn't consider those federal discounts, no.
Q. You didn't consider whether or not

365

publicly available data sources such as IMS demonstrate that the acquisition costs of Zoladex throughout the class period was at significant discounts to AWP; is that right?
A. My understanding is those data were not complete, that they did not provide a complete picture of the discounts that you see here in the calculation of ASP.
Q. Could you answer my question?
You didn't consider that --
MR. MACORETTA: Objection.
Q. -- publicly available data showed discounts off of AWP that physicians were receiving in acquiring Zoladex, right?
MR. MACORETTA: Objection.
Go ahead.
A. I certainly considered what the available information was, and I concluded that the third-party payers had insufficient information to understand the acquisition costs that their physicians were getting for Zoladex.
Q. Did you look at IMS data?

366

A. Did I look at IMS data for Zoladex?
I looked at the data behind these calculations, which are invoice data.
Q. So, no, you didn't look at publicly available IMS data?
MR. MACORETTA: Objection.
A. Yeah, I didn't look at IMS data, but IMS data don't have rebates in them.
Q. Do they have any discount information them?
A. They do have discount information.
Q. And do you know, can you tell me at any particular point in the class period what discounts off of AWP were reflected for Zoladex in the IMS data?
A. I could not tell you that right now.
Q. And that wasn't part of your analysis?
A. No.
Q. Have you -- looking at the chart again on Page 17, just focusing you on the period from 1991 to 1994, you see there in the data that you used that the spread for Zoladex AWP versus ASP

367

is 25 percent, and it appears to in 1994 go up -- I'm sorry -- strike that -- it appears in 1994 the AWP for Zoladex goes up, but so does the ASP.
Do you see that?
A. I do see that, yes.
Q. Can you explain to me why Dr. Hartman finds damages for Zoladex in 1994, but he doesn't in 1991 to 1993?
MR. MACORETTA: Objection.
A. I cannot explain Dr. Hartman's conclusions, no. .
Q. You talked about LCA.
Are you familiar with an OIG report from 2004 which concluded that Medicare and its beneficiaries in 10 jurisdictions would have saved approximately $40 million per year had they reimbursed based on Zoladex AWP as opposed to Lupron?
A. I am not sure which report you are referring to.
Do you have a copy of it?
Q. I don't.

368

Are you familiar with the fact that for Medicare and its beneficiaries the savings as a result of the adoption of LCA and the use of Zoladex was in the millions of dollars per year?
MR. MACORETTA: Objection.
A. I am not aware of that particular quantification.
I am certainly aware that the LCA policy was designed to save money because Zoladex's price was below that of Lupron.
Q. In reaching your conclusions, whatever the data turns out to be, you didn't take into effect -- into consideration the fact that your conclusions as to the harm to the class -- that the LCA saved Medicare and its beneficiaries whatever the number turns out to be, millions of dollars, did you?
MR. MACORETTA: Objection.
A. That would not be relevant to my conclusion.
Q. You didn't consider that at all?
MR. MACORETTA: Objection.

369

A. It would not be appropriate to consider that, no.
Q. In rendering your opinions as to the pricing of Zoladex and your opinion as to the harm to the class, did you do any analysis of the level of orchiectomies prior to the introduction of Lupron and Zoladex?
A. No.
Q. Any comparison of the types of preferences that patients have with respect to orchiectomies relative to Zoladex treatment or Lupron treatment?
MR. MACORETTA: Objection.
A. That analysis would not be relevant for my conclusions.
Q. You didn't take that into account at all in rendering the opinion that the class was harmed in this case, correct?
A. The definition of "harm" is a legal matter and confined -- does not include these effects that you want to discuss about tradeoffs between surgery and drug treatment.

370

Q. When you say the word "harm" is a legal matter, you use the word that the class was harmed in this case.
You weren't rendering a legal opinion there, I take it?
A. But I was asked to look at economic harm in terms of the overpayments.
Q. Do you correlate economic harm with legal harm?
MR. MACORETTA: Objection.
A. Again, I was asked to look at a specific nature of impact here.
Q. And it was economic, in terms of dollars and cents, but it didn't take into account patient preferences or the resulting savings from use of physician treatment in offices as opposed to surgical intervention?
MR. MACORETTA: Objection.
Asked and answered.
A. That's correct.
MR. MACORETTA: Argumentative.
MR. FLYNN: I think that's all I have.
MR. MACORETTA: Why don't we take a break for lunch now, which I believe is here.
THE VIDEOGRAPHER: The time is 1:03 p.m. This is the end of cassette number one. We are off the record.
(A lunch recess was taken.)

371

372

AFTERNOON SESSION
THE VIDEOGRAPHER: The time is 2:03 p.m. This is the beginning of cassette number two in the deposition of Meredith Rosenthal. We are on the record.
CROSS-EXAMINATION
BY MR. EDWARDS:
Q. Good afternoon, Dr. Rosenthal.
A. Good afternoon.
Q. I am Steve Edwards. I represent Bristol-Myers Squibb. I would like to ask you a few questions.
Do you have a copy of your report? Can you put that in front of you?
A. Yes, I do.
Q. I want to direct your attention to Paragraph 29.
A. Paragraph 29, yes.
Yes I found it. Thank you.
Q. In Paragraph 29, at the end of the paragraph you say, "The unique and perverse feature of this market is that pharmaceutical

373

manufacturers can also increase market share through raising their AWP, since this list price is the basis for third-party reimbursement. Unlike offering big discounts to physicians, raising the AWP relative to the acquisition cost to the physician does not reduce profit margins on the drug in question."

A. Profit margins for the manufacturer, yes.

Q. And then you give examples of how this may have happened; is that correct?

A. That's correct.

Q. And the first example you give in Paragraph 30 relates to a BMS document?

A. Yes, it does.

Q. And what I want to do is mark as an exhibit -- this would be Exhibit Rosenthal 015 a copy of a document entitled "Etopophos Launch Plan."

MR. STEVENS: The Bates numbers are BMS AWP 0011214 through 235.

(Exhibit Rosenthal 015 was marked for identification)

A. Thank you. I have the document.

374

Q. Is this the document that you are referring to in Paragraph 30 of your report?

A. I do believe this is the document. It looks familiar and the Bates numbers seem consistent with the ones I have, yes.

Q. And you cite a particular page which is 1121 -- I'm sorry, 11221 --

A. Yes. I see --

Q. -- or Page 6 of the document; is that correct?

A. That's correct.

Q. And you have that page in front of you?

A. I do.

Q. In Paragraph 30 of your report you say in the last two sentences, "The document explicitly references using the disparity between AWP and actual acquisition cost as a 'financial incentive' to physicians. The document then explores 'strategies' to provide 'adequate financial incentive' for physicians to use Vepesid." Is that correct?

A. That's correct.

375

Q. If you look at this document, this document talks about Etopophos, doesn't it?

A. That's correct.

Q. It talks about providing adequate financial incentive for the use of Etopophos; is that correct?

A. That's correct.

Q. Do you think perhaps you meant to say "Etopophos" instead of "Vepesid" in your report?

A. My understanding is that both of those drugs are referenced here, and that the competition with regards to the spread would apply to both of them.

I see that you're correct that it is talking about changing Etopophos relative to Vepesid, but it references both of them with regard to the financial incentive.

Q. But the document actually says -- and I am reading from the second paragraph on Page 6 -- "To provide adequate financial incentive for the use of Etopophos the following strategies could be employed." Correct?

376

A. That does say that there, and in the previous sentence I made reference to the physician practices can take advantage of the growing disparity. That's the first part of what I reference here.

Q. And it proposes two alternative strategies, correct?

A. That's correct.

Q. One strategy would be a reduction of the Vepesid AWP; is that correct?

A. That's correct.

Q. And the other strategy would be to establish a premium list price for Etopophos, correct?

A. That's correct. Right.

So these two drugs are competing with one another. My understanding is that they are therapeutic substitutes, to some extent, and the relative position of the two ASPs is the subject here.

Q. Right. Do you know whether either of these strategies were pursued?

377

A. At this particular point in time, I can't say.
Q. It didn't occur to you that it would be important to determine whether either of these strategies were pursued before you referenced this document as an example that supports your theory?
A. This document was referenced to illustrate the notion that manufacturers recognized that the spread could be an important mechanism for shifting market share.
Whether or not that was implemented at this point in time, it was not relevant to my conclusion that the manufacturers recognize the importance of the spread as a financial incentive.
Q. So what you are saying in your report, then, is that it could happen? You are not saying that it did happen?
A. I concluded in my report that the class was harmed because these incentives were present.
I observed the spread in the data. So I conclude it did happen.

378

Q. How can you conclude that the class was harmed by these strategies, either of these strategies, without inquiring as to whether they were even implemented?
A. Again, I examined the actual spreads.
Q. Okay. Well, let's look at the actual spreads.
Do you know whether BMS reduced the AWP of Vepesid?
A. Following this particular event, I do not.
Q. Did it occur to you to look at Dr. Hartman's report to see if the data in Dr. Hartman's report supported your theory?
A. Comparing this to Dr. Hartman's report was not necessary, again, for -- I drew my conclusion from an economic analysis of the incentives, from examination those natural experiments, where I could easily see cause and effect, and again, using this information to illustrate the knowledge by the manufacturers of this financial incentive.
I did not attempt to do exactly what you described.

379

MR. STEVENS: Let me mark as Exhibit Rosenthal 016 an excerpt from Attachment G of Dr. Hartman's report. This is Attachment G.2 relating to Bristol-Myers Squibb to Dr. Hartman's report of December 15, 2005.
(Exhibit Rosenthal 016 was marked for identification)
Q. Do you have Exhibit Rosenthal 016 in front of you?
A. I do. Thank you.
I'm sorry, which page again?
Q. Well, take a look at Attachment G.2.B --
A. Okay.
Q. -- which purports to reflect Bristol-Myers Squibb annual ASPs.
Do you see that?
A. I do see that.
Q. And if you look at the second page, you have the ASPs for Vepesid, correct?
A. I see that. I do.
Q. Just so we're clear here, the particular NDC of Vepesid that I believe we are talking about is the second-to-last one --

380

A. Okay.
Q. -- 9520.
A. That's the one that is referenced in the strategic memo? 9520? I am just looking.
I do see 9520. I don't see it in this text, but...
Q. I will ask you to assume for the moment, to save time, that the particular NDC of Vepesid that is being compared in this document is 9520.
And can you tell me by looking at Dr. Hartman's Attachment G.2.B whether there was any change in the AWP for Vepesid after the date of this document, which is September 6, 1995?
A. I do not see any change in the AWP there.
Q. Now, using Dr. Hartman's attachment, can you tell me whether the other aspect of the strategy proposed in Exhibit Rosenthal 015 was carried out?
A. Whether there was a change?
Q. Establishing a premium list price for Etopophos.
A. Well, excuse me. The first data point

381

that I have for Etopophos is 1996.
Would it be correct to assume that's the launch date of Etopophos?
Q. I believe the product was launched in late '95 or early '96.
A. So a premium launch price, I guess, I assume -- I would read a premium launch price as being relative to the ASP in terms of the spread that it offered.
Q. Let me see if I can help you out here little bit.
A. Yeah.
Q. You see strategy 2 --
A. Yeah.
Q. -- it says, "Establish a premium list price for Etopophos" --
A. Right.
Q. -- etoposide phosphate for injection. A list price of $120.54 would represent a 15 percent premium over the current Vepesid."
Is it your understanding that the term "list price" at BMS refers to the equivalent of

382

what I think you have called WAC?
A. I am not sure what it refers to here. It says, "the direct list price."
Q. Do you see --
A. Yeah, a list price of $120 would represent a 15 percent premium over the current Vepesid for -- for injection -- direct list price.
I am not sure what those terms convey here. I would have -- I would have thought that the $120 -- the list price would be the AWP.
Q. If you look at the first paragraph --
A. Certainly.
Q. -- of this page, it talks about the disparity between Vepesid's list price and subsequently the average wholesale price.
A. Okay.
Q. Does that suggest to you that the list price and the average wholesale price are two different things?
A. It does seem that way.
So if you tell me it is the WAC, I am certainly prepared to accept that --

383

Q. I think another way you can verify that is by looking at Page 19 of this document, which Exhibit Rosenthal 015. You'll see that there is a reference there to the wholesale list price --
A. I see that.
Q. -- and the wholesale list price for Vepesid is $109.19?
A. I see that.
Q. And if you look at the AWP for Vepesid in Exhibit Rosenthal 016 the AWP was $136.49, correct?
A. I see that.
Q. So $109.19 was the equivalent of the WAC and $136.49 was the AWP, correct?
A. That's what it appears to be, yes.
Q. So the proposal in this document for a premium list price for Etopophos of $125.57 would relate to the WAC, not the AWP?
A. I see that. Yes.
Q. Can you tell from Dr. Hartman's Exhibit Hartman 016 what list price was actually selected for Etopophos?
A. Right. It would appear that the actual

384

Etopophos price is lower than that suggested in this document by $20 or $30, something like that.
Q. Right. If the AWP for Etopophos was $124.14, then the list price -- I will tell you I have done the math -- would have been $99.31?
A. It sounds very reasonable.
Q. The alternative strategy of establishing a premium list price for Etopophos was not implemented either, correct?
A. Not as described in this document, no.
Q. Now, do you have any understanding of the extent to which BMS in fact discounted below the list price for Etopophos?
A. I have reviewed all these ASPs.
I don't have all of them committed to memory. I would be happy to look at it with you.
Q. Okay. Why don't we do that. I think if you look at Attachment G.2.A of Exhibit Rosenthal 016.
A. Okay.
Q. You have Dr. Hartman's calculation of those numbers.
A. I see that.

385

Q. And in 1996 he calculates an ASP of $91.42, correct?
A. That's correct.
Q. And that would be compared to a wholesale list price of $99.31, correct.
A. Excuse me, compared to the WAC, if it is okay if I use that term, yes.
Q. Do you want to use that term?
A. Okay. Yes.
Q. So that's a discount of less than 10 percent?
A. Off of the WAC?
Q. Yes.
A. Okay. Yes.
Q. And then for the subsequent years, the prices range from $97.74 to $99.26, correct?
A. I see that, yes.
Q. Very little discounting, correct?
A. There's less and less over time, yes.
Q. So Etopophos would not be a good example of what you have characterized as AWP inflation; is that fair?

386

A. Etopophos, my understanding, meets Dr. Hartman's theory, yardstick theory for liability here.
I have not been asked to separately make a judgment about what the liability threshold should be.
So since I have assumed his liability threshold, then it certainly meets that.
Q. Well, do you have any independent opinion based on the information I have provided you as to whether Etopophos is a good example of what you have characterized as AWP inflation?
A. There were certainly spreads in those earlier years.
I am not sure what you are getting at. There are spreads.
Q. So, in your view, there can be AWP inflation even where there is no increase in the AWP?
A. Where there is no increase in the AWP over time --
Q. Yes.

387

A. -- to be clear? Yes.
Q. Okay. And, in your view, there can be AWP inflation even where the discount below list price is less than two percent?
A. Again, I have not been asked to separately establish a threshold.
Q. Do you know for which years Dr. Hartman found that his liability yardstick was exceeded for Etopophos?
A. I could look at that.
Q. Why don't you.
A. It looks like just 1996.
Q. 1996 was the year in which Dr. Hartman calculated an average sales price of $91.42, correct?
A. Yes, that's correct.
Q. Do you know why the ASP was $91.42 in 1996?
A. Do I know separately where those rebates come from or discounts? No, I do not.
Q. Do you care why it was $91.42 in 1996?
A. I examined the methodology for calculating

388

that ASP and understood what Dr. Hartman included.
Do I care? I am not sure what you mean by that.
Q. Isn't it possible that the reason there was an ASP of $91.42 in the initial year after the product's introduction, is that BMS was offering an introductory discount in order to get people to buy product?
A. That -- it is certainly possible they were offering discounts.
The question is why the AWP didn't reflect those introductory discounts. That's the question that I would say is being addressed here.
Q. So if a manufacturer sets a list price and then offers an introductory discount in order to get people to buy the product, in your view, that is fraudulent behavior?
A. My understanding, in this context where the third-party payers are paying the list price and the discounts accrue only to the providers, that is the behavior that we are -- that's the allegations we are considering here. That's